E. SUBSTANCE ABUSE BLOCK GRANT (SET-ASIDE)

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA	$65,505,379	$79,249,794	$80,750,000	+$1,500,206

2000 Authorization

Substance Abuse Prevention and Treatment Block Grant.....Expired

Purpose and Method of Operation

The 5% set-aside of the Substance Abuse Prevention and Treatment Block Grant (SAPT) supports data collection, technical assistance, the National Data Center, and program evaluation. SAMHSA is the major source of information in the United States on the extent and nature of substance abuse, the supply and cost of services for treating substance abuse, and the number and characteristics of persons in treatment. Much of this information is produced by data systems developed and managed by the Office of Applied Studies (OAS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT). They are used by the Department of Health and Human Services, the Office of National Drug Control Policy, the Drug Enforcement Agency, and State and local agencies to plan and evaluate programs to address health and social problems.

Office Applied Studies (OAS)

Four major surveys provide the information used to formulate substance abuse policy and to evaluate performance of programs and activities supported with Federal funds. These surveys include: (1) the National Household Survey on Drug Abuse (NHSDA); (2) the Drug Abuse Warning Network (DAWN); (3) the Drug and Alcohol Services Information System (DASIS); and (4) the Alcohol and Drug Services Survey (ADSS). All of these data collection activities provide information required by Section 505 of the Public Health Service Act.

Expanded National Household Survey on Drug Abuse. The National Household Survey on Drug Abuse (NHSDA) is the largest and most widely known of the data collection activities of the Office of Applied Studies. This survey provides estimates of the prevalence of substance abuse and the number of persons who have received treatment in the civilian, non-institutionalized population. The NHSDA has been the principal source of this information since 1971. As a result, the data from this survey are employed to study trends in the use of and the attitudes about licit and illicit drugs. They also provide a unique source of information for studying the causes of substance abuse, the demand for treatment, and the effectiveness of prevention and treatment programs. These studies are carried out by staff in OAS and by researchers in the public and private sectors.

The majority of Federal funds dedicated to substance abuse treatment and prevention are distributed directly to States. States decide what programs and activities receive funds and the level of support within the requirements established by legislation. Differences between States with respect to how these funds are allocated; their policies on prevention, treatment, and enforcement; and the populations at risk make it difficult to assess the results of these Federal expenditures.

The problem of evaluating the impact of Federal substance abuse programs is made more difficult by the nature of the information available for analysis. Only national or regional estimates can be obtained from such major sources of data as the NHSDA and Monitoring the Future (MTF) because of the size of the samples. On the other hand, data collected by some States and local entities to make small area estimates use methods that vary to such an extent they cannot be used to make State to State comparisons, develop regional estimates, or even, in many cases, track trends in the same State over a period of time.

To address these problems and generate data more appropriate for studying the impact of Federal expenditures for substance abuse treatment and prevention programs, the size of the NHSDA sample will increase to about 70,000 respondents in 1999. In 1996, the sample size of the survey was 18,000. In 1997 and 1998, the sample was expanded to 25,000 to oversample in Arizona and California. With the change and modifications in the sample design in 1999, it will be possible to produce State level estimates on an annual basis. Because questionnaires and survey methods will be the same in every State, the new survey will allow comparisons between States with respect to prevalence of substance abuse and other measures, will support the analysis of State trends over time, and by accumulating several years of information for each State, will even support estimates of intra-state variations. The new estimates will not only facilitate the evaluation of SAMHSA programs, over time they will also make it possible to direct Federal funds to areas with severe or unique problems.

The NHSDA will continue to provide national estimates of the incidence and prevalence of substance abuse, the nature of the substances, and the personal and family characteristics of those involved. The increase in the sample size will make these estimates more precise than in the past, enhance the analytic value of the data, and produce better estimates of the somewhat less common types of substance abuse. However, States will in most cases have to conduct surveys and analyses to address sub-state issues and special populations issues.

The 1999 NHSDA went into the field in January, 1999. The design calls for approximately 3800 interviews in the 8 largest States which together contain more than 50% of the U.S. population. Approximately 900 respondents will be interviewed in the other 42 States and the District of Columbia. Because the survey will focus on youth, approximately 280,000 households will have to be screened to identify eligible respondents. Studies have shown that face-to-face interviews are essential for obtaining information on sensitive subjects such as substance abuse and mental health. Personal interviews are also required when the characteristics of respondents and other members of the household unit are important analytic variables.

The strategy for the expanded survey will produce direct estimates for the 8 largest States and model based estimates for the other 42 States. The information obtained from the 900 respondents in each of the latter

States will be used to adjust the modeled estimates to take into account the individual characteristics of each State. Although the small size of the State-specific samples will limit the precision of the State rankings, States can be grouped according to various measures with some confidence.

In 1999 the NHSDA is being conducted in a computer assisted mode. This technology will make it possible to provide information in the same time frame as the current survey despite the increase in scale and complexity of the new survey. Information from the current survey is available about four months after the field work has been completed. Computer Assisted Self Interviewing (CASI) also will substantially improve the quality and the validity of information provided by respondents. In subsequent years, the survey questionnaire will be modified to improve information on the household, insurance coverage, mental health status, and experience with prevention and treatment programs. Other modifications of the questionnaires and sample will be made in subsequent years to obtain information for assessing Federal substance abuse programs.

Tobacco Module of NHSDA. Beginning in 1999, the tobacco component of the NHSDA will be expanded to permit a more comprehensive set of data on tobacco product use, including information on usual brand. The FY 2000 cost of this addition to the NHSDA is estimated at $4.0 million. This expansion will require lengthening the interview to include more detailed questions. The initiative will increase by 2,500 the number of interviews with youth age 12 to 17, bringing the total sample in this age category to 25,000. This increase in sample size will achieve the desired level of precision. The $4.0 million required for this initiative is to be transferred to SAMHSA by the Department from other sources.

Other OAS Activities. Since the early 1970's, the DAWN survey has been used to identify emerging problems in substance abuse at both the national and local level. Information included in DAWN is obtained from the medical records of individuals admitted to a national sample of hospital emergency departments and from a national sample of medical examiners. The Drug Enforcement Agency uses DAWN data for surveillance and enforcement activities. The pharmaceutical industry uses DAWN to identify problems associated with the use of licit drugs, which were not detected in more limited clinical trials. Changes in the structure of the health care sector will require that the current data collection strategy be evaluated over the next two years.

The Drug and Alcohol Services Information System (DASIS) is the primary source of information on the services available for substance abuse treatment and the characteristics of individuals admitted for treatment. DASIS contains three data sets which have been developed and maintained with the cooperation and support of the States. The National Facility Register (NFR) lists all treatment facilities in the country which are recognized or approved by the States. A directory developed from the NFR is available in hard copy or online, and is used by public and private health care providers to refer patients to appropriate sources of treatment. Another component of DASIS is the Uniform Facility Data Set (UFDS), which contains detailed information on the characteristics, services, resources, and costs of treatment facilities in the United States. In FY 1997, this data set was expanded to include information on treatment programs in the criminal justice system.

A third component of DASIS is the Treatment Episode Data Set (TEDS), which contains information on

every patient admitted to a treatment facility receiving any public funds. TEDS is a relatively new data set but has become a critical source of information on admissions and the treatment process.

In addition, OAS conducts studies evaluating the effectiveness of substance abuse treatment and the validity of the information obtained from providers. The largest of these studies, the Alcohol and Drug Services Survey (ADSS), is directed by a team of investigators at Brandeis University. Among other things, ADSS was designed to describe the changes occurring in the organization and structure of the substance abuse treatment system, and to assess the impact of these changes on the process and effectiveness of treatment.

Center for Substance Abuse Prevention (CSAP)

CSAP will continue to utilize the five-percent set-aside of the twenty percent of the Block Grant designated for prevention for the improvement of State prevention systems. CSAP has utilized the funds to develop and implement advanced prevention methodology for all components of State prevention systems, including systems for data collection and performance measurement. Specific examples of activities to be continued in FY 2000 include:

- State Needs Assessments

CSAP=s State Needs Assessment Program has awarded 3-year contracts to 27 States over the past four years. The purpose of the program is to assist States increase their ability to base their prevention programming, resource allocation, and performance measurement on scientifically sound quantitative data and help improve the States= capacity and infrastructure to conduct studies and utilize data. States receiving contracts are required to conduct a core set of studies, including school-based, archival, and community resource assessments. States may also propose additional studies for funding to determine prevalence and incidence and other factors associated with substance abuse, with particular attention to high risk and special populations such as Native American, the homeless, etc. This information has been invaluable, especially to those States which have received a State Incentive Grant award, as they begin to implement science-based prevention programs to address their critical capacity needs identified through these needs assessments.

- Prevention Technical Assistance (TA) to States

CSAP has provided TA activities to more than 45 States and U.S. jurisdictions to support their substance abuse prevention systems. TA has been provided on-site, by phone, and in multi-State formats. Primary areas of assistance provided include: general TA (addressing prevention system infrastructure); youth tobacco control (helping States to develop tools and strategies to comply with the Synar regulation); minimum data set (promoting common data collection regarding service characteristics and populations served with a set of defined data elements); and State Incentive Grant support. For example, CSAP is developing a computer simulation model designed to assist in the development of comprehensive tobacco control policy. This modeling program, known as SimSmoke, can predict future smoking prevalence rates and smoking-related mortality rates for the entire U.S. population by age, gender, and racial/ethnic group.

SimSmoke can also simulate future prevalence and mortality rates in light of two types of policy interventions: price interventions (taxes) and youth access interventions.

CSAP has also provided extensive technical support and training for the directors of substance abuse prevention agencies within the States, with the intention of developing a base set of knowledge and skills within and among the States about the most effective prevention strategies and initiatives.

- Minimum Data Set Program

The CSAP Minimum Data Set (MDS) Program makes an economical, efficient, and user-friendly database management information system (MIS) available to State, sub-State, and local substance abuse prevention agencies and prevention service providers. The common data sets and definitions were developed through a consensus process with State officials and CSAP. The MIS is a PC-based software package for capturing, organizing, and reporting information on the populations served and substance abuse prevention services provided. The MIS is used on a voluntary basis to collect uniform information that informs prevention programming, resource allocation, process evaluation, measuring performance, and data sharing. The MDS Program is also designed to provide the technical assistance, training, documentation, and related services necessary for States to plan for, coordinate, install, and operate the MIS, and use the data gathered. A majority of States are now using or being trained in the MDS system.

CSAP is also planning a more advanced software system. In addition to the core set of services, the more advanced system would include variables for risk and protective factors, intermediate- and long-term performance goals and objectives, and a number of core measures from which States could select. It will have the flexibility of adding and changing outcomes and indicators as requirements change or new knowledge is developed. The system will include decision support capability and a knowledge base to inform and guide State agencies, providers, researchers, and evaluators in carrying out prevention activities.

Center for Substance Abuse Treatment (CSAT)

Currently, CSAT is responding to more than 185 specific requests from State and Territory substance abuse directors for technical assistance that is designed to enhance their jurisdictions' capacity to deliver effective treatment services, or to better manage relevant data in order to monitor outcomes. Some examples of projects funded by CSAT=s allocation of the SAMHSA set-aside are:

C Fourteen State contracts for Treatment Outcomes and Performance Pilot Studies (TOPPS), which address issues needed to improve system capability, standardization, and accountability through better defined and validated measures of substance abuse treatment outcomes and performance measures. New cooperative agreements (TOPPS-II), awarded in September, 1998, will assist States in refining management information systems to systematically monitor common substance abuse treatment effectiveness data measures on both a State and inter-State basis.

C Phase I of the State needs assessment contracts were awarded to 53 states and Territories by the end of 1997, with additional awards initiated to assist all Pacific island jurisdictions in enhancing their data

collection, analysis and management capabilities. Some States are now using data generated from the needs assessments for re-direction of State funds and measurement of services impact. States are also using needs assessment findings to guide their initial efforts at introducing and monitoring managed care activities. For example:

- Several States (MI, IL, WA, TX, MN, IO, AZ) are now using findings to inform their States= policy and budgeting development processes as well as to change their resource allocation methodologies and funding patterns. Illinois has used its needs assessment data to develop a new methodology for re-allocating funds among its regions as the Single State Authorities (SSA) develops new contracts with managed care organizations. Arizona, Colorado, North Carolina, and Texas are also using the data for these purposes.

- Iowa has used the findings of its study of alcohol and drug use among women, age 18 and over, to redesign the State=s approach to providing tailored outreach and treatment services for women. The study found that a very low proportion of those needing treatment ever received it (less than 5%), and identified some significant barriers to entering and remaining in treatment. These were: financial concerns, concerns about confidentiality and stigma, and lack of child care.

- New Jersey has used the results from several of its studies to guide the allocation among treatment programs of over $10 million in new funds. New Jersey=s data are also now being used by county level decision makers as they do their annual contracting with providers.

C Phase II of the State Treatment Needs Assessment Program (STNAP) began in 1997 and twenty seven States have received contracts. The second phase will allow repeats of some studies to get trend data as well as to carry out more sophisticated gap analyses. In response to the planned expansion of the National Household Survey on Drug Abuse (NHSDA) to provide State-level estimates of prevalence, CSAT has been collaborating with ONDCP and OAS to have the National Household Survey on Drug Abuse become the general population survey used by the States in conducting their treatment needs assessments. CSAT anticipates that the NHSDA will replace the individual State adult and adolescent telephone household surveys and school surveys now supported through STNAP.

C Arizona and several other States are conducting a comparison of their findings with NHSDA. The findings will serve as checks on the reliability and validity of the two different interview modalities used. Comparisons are now somewhat more relevant because the NHSDA=s increased sample size makes regional breakouts possible. Texas and several other States have offered to serve as pilots for this approach substituting the NHSDA for their own State telephone household and school surveys to produce prevalence estimates that can be combined with State-conducted special population and social indicator studies to yield relevant small area estimates. States are likely to choose to analyze the NHSDA results only once every 4-5 years, aggregating the yearly samples to ensure a large-enough sample size to do small area estimates and gap analysis.

Other activities, notably collaborative initiatives and training-related projects, which are being supported by CSAT are:

- Collaboration with CMHS and CSAP, the SAMHSA Office of Managed Care and with HCFA in planning training symposia nationwide for all State and mental health directors, and State Medicaid directors, on the use of a guide for substance abuse public purchasers of managed care services: ***AContracting for Managed Substance Abuse and Mental Health Services.@*** The Guide was recently developed and published as TAP # 22 in the CSAT Technical Assistance Publication series.

- The Treatment Improvement Protocols (TIPS) series, which provide state-of-the-art consensus documents on a variety of current topics in the treatment field. To date, 29 TIPS have been published and disseminated to the field. A 4-year evaluation of the TIPS was begun in 1997 to assess their impact on the field.

- State Team Building Workshops on the new Temporary Assistance to Needy Families (TANF) laws. All Single State Authorities (SSAs) and representatives from state welfare offices have attended such conferences, during which they learn from each other and help coordinate the development of their own State plans. The State evaluations of this effort have been exceptional.

Rationale for the Budget Request

A total of $80.8 million will support the continuation and expansion of all activities under the 5% Block Grant set-aside. This amount represents an increase of $1.5 million over the FY 1999 appropriation. All current surveys and studies will be maintained and some improved, as described above.

GPRA Measures of Success

GPRA Goal: This program contributes to the achievement of Goal 4 -- Enhance Service System Performance. This activity will provide information on the following:

1. Estimates of the prevalence of substance abuse at the national level, and in the 50 States and the District of Columbia.

2. Estimates of drug- related emergency department visits at the national level, and for 21 large metropolitan areas.

3. Information on the services available for substance abuse treatment in the United States, and on the characteristics of patients admitted to treatment.

Measure: Increase utility of Federal, State, and local data to enhance service system performance.